STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001062	A. BUILDING 01 B. WING	09/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification survey conducted on 02/06/20 was conducted by the Indiana State Department of Health in accordance with Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 09/08/20 Facility Number: 008902 Provider Number: 15C0001062 AIM Number: 200119350A At this PSR survey, Northside Gastroenterology Endoscopy Center LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This one story facility was determined to be of Type V(111) construction and not sprinklered. The facility has a fire alarm system with duct detectors installed in HVAC ductwork. Quality Review completed on 09/09/20	K 0000		
K 0131 Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44			
	Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier. Doors are self-closing and are kept in the closed position, except when in use. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Nurse Manager at	K 0131	Plan of Correction:The Center Administrator will ensure that no door will be propped or kept form closing at any time. The door props were removed by the Administrator. This Life Safety issue was shared with center staff and with providers at an in-service on September 18, 2020 (Attachment A and Attachment C) to inform all staff and providers that no doors in the ASC are	09/09/2020

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	1:10 p.m. on 09/08/20, the entrance door to the patient waiting area inside the facility suite from the corridor was propped in the fully open position with a wedge placed under the door. The corridor door is in the tenant separation wall. Based on interview at the time of the observations, the Nurse Manager stated the HVAC system serving the waiting area and adjoining offices within the suite is operable but lost its ability to cool the areas within the last couple of weeks, the corridor door was propped open to provide cool air from the corridor and stated a work order has been submitted to repair the HVAC system. Based on review of "Service Request #11969348" documentation in an email to the facility dated 08/28/20 with the Nurse Manager at 1:45 p.m. on 09/08/20, the facility submitted a request to the building management company for HVAC repair on 08/28/20.		allowed to be propped open in compliance with Life Safety Code. All staff and providers share the responsibility to report any episode of any door that is propped to the Administrator or Executive Director, and/or Medical director for immediate resolution of self-closing doors and kept in closed position, except when in use. Systemic Changes:The Center Administrator is responsible to conduct periodic rounds to ensure no door is propped open and to reeducate the ASC staff and provider to the NFPA requirement to keep doors and pathways free from obstructions and that it is shared responsibility that all staff and providers reporting any episode of doors propped open for immediate resolution to keep in closed position. Monitoring and Responsible Party: The Administrator is responsible for implementing ongoing observation audits to ensure facility door/ corridor door will not be propped or wedged to stay open. The Administrator is responsible for conducting observation audits (Attachment D) daily for 3 consecutive weeks to ensure 100% compliance and to correct any episode of non-compliance. Ongoing monthly audits will be documented on the Environment of Care rounds and the in-service and weekly audits	

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			will be reported to the QAPI committee and Governing Board	
K 0211 Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all patients, staff and visitors if needing to exit the facility from the patient waiting room. Findings include: Based on observations with the Nurse Manager on 09/08/20 at 1:10 p.m., four wooden chairs were placed up against the wall in the exit discharge in the corridor outside the patient waiting room. Each chair projected two feet into the six foot wide corridor. Based on interview at the time of the observations, the Nurse Manager stated the chairs were placed outside the facility suite in the corridor to provide more space for social distancing of patients and visitors while awaiting their appointment but agreed the corridor was not free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 0211	(K 211) Means of Egress- NFPA 101 Plan of Correction: The administrator is responsible to ensure the hallways and means of egress remain unobstructed in the ASC. The surveyor observed the 4 chairs place in the hall to allow for additional social distancing and were obstructing egress the chairs were removed by the Center Director. An inservice was held with staff and providers to inform them of this deficiency and to notify the administrator before moving chairs or seating to the hallways(Attachment B and Attachment C). System Change To prevent this from happening again, the Administrator is responsible to monitor the hallway to ensure no chairs or objects are placed in the hallway path of egress to ensure emergency workers can enter unobstructed and individuals can egress the building unobstructed.	09/09/2020

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			All staff share the responsibility for reporting any possible obstruction to the Center Administrator or, Executive Director, or Medical director for immediate resolution of the obstruction. This Life Safety issue was shared with center staff at an inservice on September 18, 2020. Monitoring and Responsible Party: The Center Administrator is responsible for implementing observation audits (Attachment E) for compliance with hallways free from obstructed egress for 3 weeks consecutive weeks to ensure100% compliance with life safety NFPA 101, then monthly for 3 months. This measurement will be added to the Environment of Care rounds document. These results will be shared with the QAPI committee and Governing Board on a quarterly basis	